STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC	725 SOUTH SECOND ST BOONVILLE, IN47601

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 6/27/11. This survey resulted in a partially-extended survey - Immediate Jeopardy. This visit was in conjunction with the Investigation of Complaint IN00094056 which resulted in a partially extended survey and Immediate Jeopardy. Survey date: August 18, 2011 Extended Survey date: August 19, 2011 Facility number: 000451 Provider number: 155508 Aim number: 100266240 Survey Team: Carole McDaniel RN TC Terri Walters RN Martha Saull RN Census Bed Type: SNF/NF: 64 SNF: 1 Total: 65 Census Payor Type: Medicare: 13 Medicaid: 42	F0000	September 6, 2011 Kim Rhoades Indiana State Department of Health Long Term Care Division 2 North Meridian Street Indianapolis, Indiana 46204 Dear Ms. Rhoades, Attached you will find the plan of correction for the most recent survey. Please accept our plan of correction as our allegation of compliance effective August 29, 2011. We respectfully request that a follow-up survey occur in the near future. We believe that the facility has implemented all necessary interventions to assure compliance. If you have any questions, or require further information, please don't hesitate to contact me. Respectfully Submitted, Michael Van Hoy, Administrator Transcendent Healthcare of Boonville 812-897-1375	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 10 Total: 65 Sample: 9 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/26/11 by Suzanne Williams, RN			
F0323 SS=J	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide services to prevent elopement, resulting in wrist fracture and hospitalization for 1 of 1 resident who had eloped in a sample of 9 (Resident A). In addition to Resident A in Immediate jeopardy, the facility failed to adequately identify, assess and implement an effective security system for 12 other residents at risk of elopement out of the facility census of 65. (Residents B, C, D, E, F. J, K, L, M, N, O, P) The immediatte jeopardy began on6/26/11 when Residentt A eloped ffrom tthe ffaciliffyll and ffracttured her wristt The Administtrattor and Directtor off Nursing were nottffed off tthe	F0323	**F323** **Iti is tihe practice of Transcendenti Healtihcare of Boonville tio assure tihati our residentis are in a safe secure environmenti We believe we tiook appropriatie actions for residenti A when she retiurned from tihe hospitial The residenti was placed on tihe secure uniti ati tihati time. All of tihe residentis tihati are ati risk of elopementiwitih tihe exception of one, reside on tihe secure uniti The exception is a dependenti residenti who mobilizes per wheelchair and would noti be able tio open tihe doors tio leave tihe facilitiy per self This facilitiy does noti have a histiory of residentis eloping from tihe facilitiy and will continue tio stirive tio assure tihati tihis tiype of incidenti does noti occur**	08/29/2011

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	immediatte jeopardy att 3:30 p.m. on 8/18/11. The immediatte jeopardy was removed on 8/19/11, butt noncompliance remained att tthe lower scope and severitty level off patternno acttual harm witth pottenttal ffor more tthan minimal harm tthatt is nott immediatte jeopardy. Findings include: The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included but were not limited to schizophrenia, autism, developmental disability and heart disease. The resident had been admitted to Transcendent nursing home on 2/3/11. The Minimum Data Set Assessment of 6/26/11 indicated the resident's cognition to be moderately impaired with a score of 12 (8-12 moderate impairment, 13-15 cognition intact). It indicated the resident was independent in transfers and ambulation and was always easily distracted or out of touch or had difficulty following what was said. The 7/06/2011 Interdisciplinary Diagnostic and Evaluation Center Significant change analysis provided the only available intact account of the resident's elopement in the clinical record that could be located, according to interview with the Director of Nursing on		***The correcton acton taken fior those residents fiound to be afiected by the deficient practce include :*** Residentt A remains on tthe secure unitt.The residentt's elopementt assessmentt has been updatted witth an Intterdisciplinary Team review and narrattve as well as tthe plan off care has been updatted Residentts B, C, D, E, F, J, K, L, M, N, O, and P have been reviewed and had elopementt assessmentts updatted witth an Intterdisciplinary Team review narrattve as well as tthe plan off care has been updatted The elopementt binder has been updatted tto be inclusive off each off tthe residentts identttffed abovve ***Other residents that have the potental to be afiected have been identfied by :*** All residentts have been reviewed relatted tto risk ffor elopementt witth ttheir assessmentts updatted.Any residentt identttffed tto be att risk ffor elopementt has a plan off care in place witth appropriatte intterventtons relatted tto assuring residentt is saffe ***The measures or systematc changes that have been put into place to ensure that the deficient practce does not recur include :*** Att tthe ttme off admissionquartterly and/or iff tthere is a change off conditton, tthe residentt will have an elopementt assessmentt completted The Intterdisciplinary Team will review tthis assessmentt and make a narrattve notte relatted tto tthe	

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	8/18/11 at 1:30 P.M. Excerpts from that analysis are as follows: "...admitted to Transcendent 2/3/11...admitted to (Name) Psychiatric Hospital in March 2011 where she was held for 72 hours due to threats to leave the nursing facility...most recent admission to [psychiatric hospital] was on 6/27/2011 after she snuck out of the nursing facility after 11:00 P.M. on 6/26/11, walked to a convenience store, fell on her walk back, and broke her right arm...(Resident name) had reported she had asked for a cigarette but she was told she did not have any. Reportedly she went back to her room, dressed in street clothes, then snuck out through a dining room door. (Resident name) had the code to exit the door without setting off the alarm system as she was able to go in and out to a side porch for smoking times. (Resident name) then walked to a (Name) store, about a mile from the nursing facility and fell on her return walk back. She related afterwards, she was going to purchase cigarettes. However, her roommate at the nursing facility told staff that (Resident name) was going to meet a man the roommate knew and had arranged to meet (Resident name). The man's name was learned but it is not known if (Resident name) actually met up with him. When the nursing facility did their		elopementt risk Appropriatte intterventtons will be implementted and identtffed on tthe plan off care. Any residentt identtffed tto be att risk ffor elopementt,twill have ttheir pictture as well as descripttve infformatton placed in tthe elopementt book. The elopementt book will be keptt updatted as new residentts are admitted or tthere is a change in a currentt residentt's sttattuhs. In additon, tthe door key pad codes have been changed and will be changed on a routtne basis. The knowledge off tthe key pad codes will nott be shared witth tthe residentts. All sttaff has been inserviced relatted tto elopementt risk and intterventtons, tthe keypad code changes, and tthe locatton off tthe elopementt book Please see below ffor systtems ffor monittoring ***The correctve acton taken to monitor perfiormance to assure compliance through quality assurance is:*** A Perfformance Improvementt Tool has been inittatted tthatt randomly reviews 5 residentts(especially know residentts witth risk ffor elopementt combined witth all residentts)tto assure tthatt all intterventtons are in place tto assure ttheir saffetty. The Directtor off nursing,or designee, will complette tthis ttool weekly x3, monttthly x3, and quartterly x3. Any issues identtffed will be immediattely correctted The Qualitty Assurance Committee will review tthe ttools att	

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	resident census at midnight they found she was missing from her bed. After a search of the facility with administrative personnel called in to help search and family notified, the facility received a call from (Name) Hospital Emergency Room to inform them the resident had been brought there for treatment. In relation to the above noted March 72 hour hospitalization, following threats to leave the nursing home, there was corresponding documentation in the business office of a hospitalization on March 14, 15, 16, 2011 followed by readmission to the facility. A 3/14/11 social services note included the resident "States she is leaving today. 'I am going back to my husband'...Dr (name) told nurse the cops will be here today to take (resident) to the hospital to get an evaluation and hold her 72 hours." A 3/18/11 social service note after the return of the resident to the facility indicated a continuing resident agenda to leave "tearful and somewhat angry because she wants her money so she can leave with her husband." Documentation was lacking of an elopement risk assessment until 5/2/11. The front page of this assessment was completed; however, the back page categories for summary,		tthe scheduled meettngs witth recommendattons as needed ***The date the systemic changes will be completed:*** 8-29-11	

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	conclusions/recommendations and interventions were blank with the signature of the LPN responsible entered at the bottom of the page. The Care Plan from 3/28/11, after the hospitalization for threats to leave, did not address wandering/ elopement risk. The elopement risk was not addressed until 7/10/11, after the elopement and injury with hospitalization and return to the nursing facility's locked secured unit. That care plan had a single intervention "secured unit." Documentation was provided by the facility on 8/18/11 at 11:15 A.M. regarding an investigation of the 6/26/11 elopement, with witness accounts. Excerpts included: From the investigation portion, "At 9:00 P.M. (6/26) the documentation indicated that the resident was still angry and stated that if the guy shows up, she is leaving the facility and no one is going to stop her..." From the night shift CNA witness statement "...around 11:00 P.M. (Resident name) was on the back porch sitting." From the RN witness statement "At 11:15 P.M. asked this nurse for cigarettes and wanted to smoke. Was upset when I told			

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	her I did not smoke and felt it was late and dark outside. She was upset and started to talk about events that happened earlier in the day...offered opportunity to verbalize and invited to stay at the nurses station to talk...would not reply and at 11:30 P.M. returned to her room...At 12 midnight census bed check the resident was recognized to be missing...search began and at 12:55 A.M. the hospital called to report the resident admission to the ER." Documentation was lacking to identify facility assessment of elopement risk, preventive monitoring of security breaches i.e. resident knowledge of codes, resident outdoors at night unsupervised, resident expressed elopement ideation or a plan of care to address these problems. Documentation of the event of the 6/26/11 elopement was absent from the medical record as well as all documentation of any staff responses, notifications or communications with either the first hospital ER or the psychiatric hospital to which the resident was sent. During interview with the current DON on 8/18/11 at 1:00 P.M. and on 8/19/11 at 9:30 A.M.,she indicated the documentation was "missing" and she was at a loss to know what happened to it, and believed it could not be located.			

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On 8/18/11 the undated policy and procedure for elopement prevention was reviewed. It directed "Obtain information during pre-admission screens with the resident and family regarding any history of wandering or a potential for wandering. All instances of wandering or attempted elopement will be recorded in the medical record. Upon assessment, Care Plan will be developed and implemented with specific approaches and goals for the wanderer. Upon assessment if a resident is identified as an elopement risk the resident's name, picture and physical description are placed in the wander book located at the nurses station."

On 8/18/11 the facility identified 13 residents at risk of elopement in the facility. They were Residents A, C, D, E, F, J, K, L, M, N, O, and P housed on the locked unit. The remaining elopement risk, Resident B, was housed on the regular open unit where residents were given codes by staff to use for smoking on the porch. Of the 13 residents identified to have a risk of elopement, Resident A was the only resident pictured or described in the wander book.

On 8/19/11 at 10:00 A.M. LPN #1 was interviewed regarding security practices on her open unit. She indicate several

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	alert and oriented residents knew codes and had the capability of letting other residents out or sharing the codes although she did not know if that "happened very much." She indicated Residents G, H and I knew the codes for sure and had free access. On 8/18/11 the porch door of the facility was observed to be a double wide glass door with a double key pad system of locking and a resonator which was functioning properly when manual numerical code entry was made. Residents were observed to request assistance of staff to enter codes when they were unable to do so, often related to physical inability. Resident G and I were observed to enter the codes and exit the door independently, mid morning several times between 10:00 A.M. and 11:00 A.M. Resident G was asked how to obtain the code and stated "You get it from any of them (referring to staff). There is only one code; it's always the same." An Immediate Jeopardy that began on 6/26/11 was removed on 8/19/11 when the facility reconfigured security codes and implemented a policy prohibiting the codes being given to residents, reassessed and identified all residents at risk of elopement in the facility, revised and			

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	updated the Elopement Identification book with resident photographs, and inserviced staff on the changes, but the noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with the facility continuing to assess implementation and its effectiveness. This deficiency was cited on 6/27/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2)			